New Hampshire Board of Medicine

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NEWSLETTER

News Editor: Penny Taylor, Administrator

WINTER, 2007

BOARD NEWS:

Personnel

The Board would like to welcome the following new members: Brian T. Stern, Esq. of Dover, New Hampshire, public member. Mr. Stern is a private-practice attorney in Dover. Robert J. Andelman, M.D., replacing James H. Clifford, M.D. Dr. Andelman is a board certified anesthesiologist practicing in Portsmouth. Gail Barba of Concord, New Hampshire, public member. Ms. Barba served on the New Hampshire Board of Nursing for over ten years.

The Board would like to thank James H. Clifford, M.D. of Lee, NH who served on the Board of Medicine from December 15, 1999 through January 3, 2007.

The Board would like to thank Mary S. Nelson of Nashua, NH who served on the Board of Medicine from December 19, 2001 through March, 2007.

Election of Officers:

At the December 6, 2006 meeting, the Board elected officers for the coming year. Kevin R. Costin, P.A. of Manchester, New Hampshire was elected as President and James G. Sise, M.D. of Keene, New Hampshire was re-elected as Vice President. Mr. Costin is the first physician assistant to serve as President of the New Hampshire Medical Board, and second in the country.

RELEASE OF MEDICAL RECORDS:

The Board is aware that there has been some confusion regarding the release of medical records. The Code of Administrative Rules, Med 501.02(f)(4) states:

> "Upon receipt of a written release, the requested transfer of medical records shall: a. not be delayed, including for non-payment of services; and b. be accomplished in any case within 30 days from the receipt of the signed release, unless the nature of the medical treatment requires an immediate response from the licensee."

Please be advised that the Board's interpretation of this rule is that the physician must release the medical records whether or not they have received payment for those medical records.

Disposal of Controlled Drugs in Possession of Practitioner:

NOTICE TO ALL PHYSICIANS: RSA 318-B:17-a, the Board of Pharmacy Controlled Drug Act, states "No person other than the pharmacy board, its officers, agents, and inspectors is authorized to destroy any out-dated, deteriorated, excessive or otherwise unwanted or confiscated controlled drugs which are in the possession of a practitioner, veterinarian, pharmacy, peace officer, nursing home, manufacturer, wholesaler, clinic, or laboratory or hospital. No payment shall be made to any person or institution for any drug surrendered for destruction. A record shall be maintained which indicates the name, strength, and quantity of all drugs destroyed; the place and manner of destruction; the date and time destroyed; the name of the practitioner or institution surrendering the drugs; and the signature and title of the person witnessing destruction. Such records shall conform to any federal requirements and shall be open to inspection by all federal or state officers charged with the enforcement of federal or state controlled drug laws."

From the Office of Allied Health Professionals:

The Occupational Therapy Governing Board needs a physician to serve on their Board. Currently, the monthly Board meetings are held on the 4th Monday of the month at noon. A change in the composition of the members could affect the meeting date and time by consensus.

Please contact V. Roni Soucy at the Office of Allied Health Professionals at 603-271-8390 for more information. This would also be a perfect opportunity for a retired or semi-retired physician. Active or retired with knowledge of occupational therapy a plus.

Communication – The Most Common Medical Procedure

Maysel Kemp White, PhD[a]
Sally Garhart MD[b]
Deanne Chapman PA-C[c]

Most providers take communication for granted and don't recognize it as the most commonly used medical procedure in clinical practice. On average a physician conducts over 200,000 clinical interviews during his or her medical career yet few continuing educational hours are spent updating communications techniques and unfortunately no formal measure of competency currently exists after residency. Most view good communication as a gift someone is born with, not a learned skill that requires updating just like every other medical procedure. Communications in the medical environment should be clear, accurate and non-offensive.

A busy internist asks "Why would I want to improve my communication skills? I just want to get the job done and get home. I have more patients than I need. If I start the patient talking, I'll never finish!" Interestingly most patients don't want to see a medical provider either; going to the doctor is not anticipated in a positive way. "Marcus Welby MD" is ancient fiction.

Most patients lack the skills to assess the technical quality of a health care encounter but they can appreciate the quality of "the human connection". Specifically, patients listen to what we say and how we say it. Providers and patients come to the encounter with different concerns: a patient focuses on symptoms and their impact while the provider focuses on making an accurate diagnosis, facts, and treatment. Communications training emphasizes the "Art of Listening" and practices techniques to connect with the patient.

Research highlights a number of common communication problems in provider-patient encounters. Most physicians are aware that they should ask open-ended questions and let the patient give his story yet studies indicate physicians interrupt patients 23 seconds into their history and start asking directed questions[1]. When confronted with this statistic most physicians either deny that this pertains to them or rationalize that if they don't direct or "help" the patient give the correct story then they'll miss key information and compromise the flow of their already tight schedule. What this early interruption really loses is patient trust and cooperation. When physicians become patients, they don't tolerate that kind of treatment and won't give up control of the encounter.

Another glaring research statistic it that 50% of psychosocial and psychiatric problems are missed in primary care. It's hard to recognize tangential thinking or pressured speech patterns if the provider stops the patient's discourse to ask specific, short-answer questions. Other studies show that 50% of patient problems and concerns are neither elicited by the clinician nor disclosed by patients[2] and patients are dissatisfied

with the amount of information given by their clinicians[3]. Most discussions leading to clinical decisions in primary care do not fill the criteria of informed decision making[4]. Providers often miss clues about emotional aspects that may impact their health [5, 6] and have difficulty asking about troubling, personal matters. Substance abuse and depression are two specific concerns that are frequently missed for all patients but even more often when a physician or other health care professional is "the patient". Providers fear getting "too personal" in the history taking.

Poor communication has been found to be the most common reason for patient dissatisfaction with care[7] which can lead to a change of medical provider and significant financial losses. Problematic relationship issues were identified in 71% of patient plaintiff depositions in malpractice cases[8]. Levinson[9] identified specific behaviors associated with clinicians who were not sued versus their colleagues with a history of suits: no-claims physicians used more statements of orientation (educating the patient about what to expect and the flow of the visit), used more facilitative comments (soliciting patient opinions, checking understanding, and encouraging patients to talk), used humor, and laughed more with patients. These are all skills that can be taught. Several NH malpractice insurance carriers sponsor or recommend communications workshops with goals of improving quality of care and minimizing malpractice risk.

Effective provider-patient communication positively impacts health outcomes both directly and indirectly by improving diagnostic accuracy, increasing adherence, increasing both patient and clinician satisfaction and reducing exposure to malpractice litigation. Additionally, there is evidence that excellent communication can impact the bottom line for health care organizations.

More accurate and complete patient information can contribute directly to an increase in accuracy of diagnosis and dramatically improve patient satisfaction survey results. Numerous studies indicate that the interpersonal skills of the clinician are one of the most important predictors of patient adherence because of good rapport, empathy, and open communication[10]. Patient involvement and participation in care, as well as their question asking, information exchange, and shared decision-making, are significantly correlated with patient outcomes, particularly when these are encouraged by physicians[11, 12, 13]. Patients tend to be more satisfied and experience fewer symptoms and health problems when they are able to voice their concerns and have their needs for information met[14].

In a meta-analyses of 47 studies, Roter found patient satisfaction was most consistently related to specific physician communication skills such as information giving, partnership building, positive talk and social talk but not question asking[15].

Suchman and colleagues[16] found four factors that influence clinician satisfaction: quality of the relationship, adequacy with the data collection process, time used appropriately during the visit, and patients' non-demanding and cooperative nature. Quality of the clinician-patient relationship was the

most important predictor of global satisfaction for clinicians. With a critical shortage of primary care providers, healthcare systems are being short sighted if they don't provide communications education to enhance provider satisfaction

Communication is a critical medical procedure that can be learned. It is a core competency as important as procedural skills and an essential function for all providers. Communication mastery requires education, systematic practice, feedback, and coaching. The learning is easily carried over into other interpersonal communications. More than half of the participants at a recently sponsored communications workshop of the NH Physicians' Health Program entitled "Dealing with the Difficult Patient," said that they planned to use their new skills and techniques both in the practice setting and at home communicating with their teenaged children.

a. CEO, President, Healthcare Quality and Communication Improvement, LLC
b. Sally...where from..
c. Deanne...where from.

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Pitfalls in Oxycodone testing

The Board of Medicine has become aware of a problem with immunoassays for synthetic and semi synthetic Opioids. This involves Opiates such as Methadone, Oxycodone, Hydrocodone, and Hydromorphone. Compliance testing for these drugs may result in false negative reports (absence of the drug by assay). For those patients that are tested for compliance with the prescribed medicine, a negative result may be interpreted as diversion or other Opioid abuse and could result in inappropriate patient discharge.

Oxycodone is metabolized by Demethylation to Noroxycodone and Oxymorphone followed by Glucuronidation. Following use of Oxycodone, one may detect in urine Oxycodone only, or Oxycodone and Oxymorphone, or Oxymorphone only. Commercial laboratories generally rely on immunoassays for detection of Opioids, originally designed for Codeine, Heroin and Morphine. For Oxycodone (likewise other semi synthetic drugs), urine specimens frequently do not show due to the metabolized fractions. Instead, the opiate must be analyzed by GC/MS (Gas Chromatography/mass spectrometry) or other specialized methods in order to obtain an accurate indication of Oxycodone presence. Even GC/MS may have false negative results due to instability of derivatives, out dated chromatography, wrong specimen, etc. The laboratory should be informed of the specific drug, and be requested to lower the report threshold in order to pick up a low concentration. Dilution of urine can also result in false negative reports. Very low Creatinine levels indicate dilution, and request for "no threshold testing" can at least indicate presence of the drug. Finally, the urine drug concentration has no relationship to the amount of drug ingested.

The Board wishes to illuminate the issue of testing for Oxycodone and other semi synthetic opiates. It is recognized that negative reports for compliance testing could indicate diversion, but may also indicate a false negative report. Please be aware of this issue, and consider further more specific testing before dismissing a patient, perhaps improperly.

PLEASE SEE REVERSE SIDE FOR REFERENCES.

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NH RSA 632-A:2: An Unpleasant Reality for Medical Treatment Providers since 1992. The Potential Disciplinary and Criminal Sanctions for Physicians Found to have engaged in Sexual Misconduct

Love may not be the answer: Legal realities for physicians who engage in sexual relationships with patients, former patients and key third parties

Sexual or romantic relationships between a physician and a patient or a physician and a key third party in a patient's care, generally constitutes a violation of the Code of Medical Ethics. In addition to the potential sanctions a physician may face from the Board for unethical conduct, New Hampshire criminal law also imposes penalties for sexual contact with patients. This article will familiarize practitioners with the ethical principles and laws that govern sexual contact with a patient.

New Hampshire statute RSA 329 and a set of Medical Administrative Rules ("Med rules") govern the conduct of physicians in New Hampshire. The Med rules incorporate the Code of Ethics of the American Medical Association ("AMA Code") and its Current Opinions with Annotations ("Opinions"). RSA 329 and the Medical Administrative Rules can be found on the Board's website at www.nh.gov/medicine. The AMA Code can be obtained from the AMA at www.ama-assn.org/go/ceja.

The following references set out the current law and a physician's responsibilities. References to "the board" refer to the NH Board of Medicine.

> **RSA 329:17, VI** states that "The board, after hearing, may take disciplinary action against any person licensed by it upon finding that the person:" The statute goes on to list a number of specific instances of conduct (a) through (k) for which a licensed person may be subject to discipline.
>
> **RSA 329:17, VI (c)** states that the Board may discipline a physician who: "Has displayed a pattern of behavior which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof."
>
> **RSA 329:17, VI (i)** states that the Board may discipline a physician who: "Has willfully or repeatedly violated any provision of this chapter or any substantive rule of the board."

The Med rules are adopted by the Board to establish specific rules of conduct and the procedures by which the Board regulates the medical profession in New Hampshire. The Med rules are incorporated into the statute by RSA 329:17, VI (i). The AMA Code and Opinions are incorporated into the rules by Med 501.02 (h), Standards of Conduct, which reads: "A licensee shall adhere to the Code of Medical Ethics – Current Opinions With Annotations [...] as adopted by the American Medical Association."

The AMA Code addresses sexual misconduct in Opinion 8.14, "Sexual Misconduct in the Practice of Medicine," and Opinion 8.145, "Sexual or Romantic Relations between Physicians and Key Third Parties." These Opinions are the guiding principles that the Board must use to evaluate any allegations of sexual misconduct by a physician.

Opinion 8.14 "Sexual Misconduct in the Practice of Medicine"

Opinion 8.14 states:

"Sexual contact that occurs concurrent with the physician-patient relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the physician-patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care and ultimately may be detrimental to the patient's well-being.

If a physician has reason to believe that non-sexual contact with a patient may be perceived as or may lead to sexual contact, then he or she should avoid the non-sexual contact. At a minimum, **a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic or sexual relationship with a patient. (emphasis added)**

Sexual or romantic relationships between a physician and a former patient may be unduly influenced by the previous physician-patient relationship. Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influenced derived from the previous professional relationship. (Principles of Medical Ethics implicated I, II, IV)."

Opinion 8.145 "Sexual or Romantic Relations between Physicians and Key Third Parties

Opinion 8.145 states:

"Patients are often accompanied by third parties who play an integral role in the patient-physician relationship. The physician interacts and communicates with these individuals and often is in a position to offer them information, advice, and emotional support. The more deeply involved the individual is in the clinical encounter and in medical decision making, the more troubling sexual or romantic contact with the physician would be. This is especially true for the individual whose decisions directly impact on the health and welfare of the patient. Key third parties include, but are not limited to, spouses or partners, parents, guardians, and proxies.

Physicians should refrain from sexual or romantic interactions with key third parties when it is based on the use or exploitation of trust, knowledge, influence, or emotions derived from a professional relationship. The following factors should be considered when considering whether a relationship is appropriate: the nature of the patient's medical problem, the length of the professional relationship, the degree of the third

party's emotional dependence on the physician, and the importance of the clinical encounter to the third party and the patient. (I, II)

Some professional specialties, such as psychiatry, have additional, more restriction rules that govern such relationships.

In New Hampshire, a physician on one who who engages in sexual contact with a patient may also face criminal charges. In 1992, a law was passed that criminalizes sexual penetration of a patient by a physician or one providing therapy, medical treatment or examination of the patient during the course of the physician-patient relationship or within one year of terminating the relationship. This is a Class A Felony offense of Aggravated Felonious Sexual Assault that carries a maximum sentence of ten to twenty years in prison per count.

RSA 632-A: 2 states:

> I. A person is guilty of the felony of aggravated felonious sexual assault if such person engages in sexual penetration with another person under any of the following circumstances:

Subparagraph (g) states:

> (g) When the actor provides therapy, medical treatment or examination of the victim and in the course of that therapeutic or treating relationship or within one year of termination of that therapeutic or treating relationship:
>
> (1) Acts in a manner or for purposes which are not professionally recognized as ethical or acceptable; or
> (2) Uses this position as such provider to coerce the victim to submit.

It is important for physicians to know that consent by the patient to sexual contact or penetration is not a defense to either an ethical or criminal violation. Neither is ignorance of the law a defense. A physician who finds him or herself attracted to or even in love with a patient or key third party must abide by these rules before taking any steps towards a romantic or physical relationship. It is not relevant that the patient is a reasonable, consenting adult or that the level of care was superficial or brief. These laws, rules and principles apply to all physician-patient relationships. Despite how inconvenient or even painful it may be to follow these laws, rules and principles, a physician's conduct must remain in compliance with them. A physician who fails to abide by these laws and ethical principles risks losing his or her license to practice medicine and also risks going to prison.

For more information, the NH Professionals' Health Program offers trainings in the areas of maintaining appropriate professional boundaries. In addition, the Director of the NH Professionals' Health Program is available to visit individual medical centers and hospitals upon request to discuss sexual misconduct and other boundaries issues.

"History does not entrust the care of freedom to the weak or the timid."
-GEN Dwight D. Eisenhower

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BOARD ACTIONS:

The following final board actions were taken by the Board from August 1, 2006 through December 31, 2006.

Terry Bennett, M.D. – Rochester, NH
8/4/06 - The Board of Medicine issued an Order, to dismiss the adjudicatory/disciplinary proceedings in Docket No. 05-03 regarding Dr. Terry Bennett, pursuant to the June 30, 3006 Superior Court order enjoining the Board from prosecuting Dr. Bennett as a result of the complaints in Docket No. 05-03.

Jason S. Henderson, D.O. – Berwick, ME
09/11/06 the Board of Medicine denied a request for license reinstatement from Jason Henderson, D.O. The Board finds that Dr. Henderson is not in compliance with his Consent Decree dated June 14, 2004.

Sankar N. Banerjee, M.D. - Cambridge, MA - License #8871
09/11/06 - The Board of Medicine confirmed its denial of Sankar Banerjee M.D.'s request to reinstate his license. The Board finds that Dr. Banerjee did not submit the appropriate verification for compliance demonstrating that he has satisfactorily remediated all the areas of deficiency noted in the CPEP report of June 28, 2004; and the remediation required by the Board in October 18, 2005 Order or the February 7, 2005 Order. Therefore, the Board denied Dr. Banerjee's request for reconsideration.

Christopher G. Carter, P.A. – Bedford, NH
09/12/06 - Christopher Carter, P.A. entered into a preliminary agreement for practice restrictions with the Board of Medicine. Mr. Carter has professional misconduct allegations pending before the Board. He has contracted with the NH PHP and voluntarily agrees not to practice medicine, not to write prescriptions, and not to treat or see patients in the State of New Hampshire or in any other state where he may hold a license to practice medicine until further order of the Board and written recommendation of the Director of the NH PHP.

David M. Kessner, M.D. – Kittery Point, ME
09/12/06 - The Board of Medicine accepted a Voluntary Surrender of License from David M. Kessner, M.D. Before the Board are allegations that Dr. Kessner failed to maintain an appropriate physician/patient relationship. Dr. Kessner has undergone a psychological and psychiatric assessment that led him to retire from the practice of medicine.

Stephen J. McColgan, M.D. – Long Beach, CA
10/09/06 - The Board of Medicine issued a Settlement Agreement for Stephen J. McColgan, M.D. The Medical Board of California, Division of Medical Quality, issued afinal administrative order regarding the disposition of disciplinary matters relating to repeated negligence, incompetence, violation of drug statutes, and failure to maintain adequate records during the treatment of his ex-wife and of his minor child. Accordingly, the New Hampshire Board has taken reciprocal action. Dr. McColgan is reprimanded and shall provide documentation to the New Hampshire Board of his compliance with the terms of the California Board's order no later than August 21, 2007.

Romauld N. Sluyters, M.D. - Bedford, NH
11/3/06 - The Board of Medicine approved a Settlement Agreement for Romuald N. Sluyters, M.D. The Board received information that Dr. Sluyters was engaged in a consensual sexual relationship with Patient A. On July 7, 2005 the Board issued an Order of Emergency Suspension. Dr. Sluyters is reprimanded and his license is suspended for a period of five years. Dr. Sluyters shall provide the Board with a copy of the Professional Renewal Center's recommendations and shall contract with the NH PHP for a period of five years. Dr. Sluyters is assessed an administrative fine of $1,500.00.

Fathi El-Kurd, M.D. – Bedford, NH
11/3/06 - The Board of Medicine approved a Settlement Agreement for Fathi A. El-Kurd, M.D. The Board received information that Dr. El-Kurd's practice of medicine has fallen below the standard of care when he practiced outside the scope of his specialty in surgery. Dr. El-Kurd agrees to limit his practice to his specialties of general and vascular surgery and to attend one continuing medical education course listed in the Agreement.

Heather Mudgett, P.A. – Pembroke, NH
11/03/06 - The Board of Medicine approved d a Settlement Agreement for Heather Mudgett, P.A. The Board received information that Ms. Mudgett had written Schedule II controlled prescriptions for family members. Ms. Mudgett is reprimanded and her license is suspended for a period of one year. Ms Mudgett must participate in programs of continuing medical education in the following areas: 1) controlled substance prescribing course; and 2) professional boundary course or counseling at a facility that specializes in maintaining professional boundaries.

The Board has also issued 24 confidential letters of concern, pursuant to RSA 329:17, VII-a, from August 1, 2006 through December 31, 2006. These letters advise the licensee that while there is insufficient evidence to support disciplinary action, the Board believes the physician should modify or eliminate certain practices, and that continuation of the activities which led to the information being submitted to the Board may result in action against the licensee's license. These letters are not released to the public or any other licensing authority, except that the letters may be used as evidence in subsequent disciplinary proceedings by the Board. A total of 118 consumer complaints, writs from the Courts, malpractice claims and complaints from other sources were received during that time frame.

- **The Board office is at times called about requests for further details about certain disciplinary actions. All Orders are public documents and may be obtained by calling the Board office at (603) 271-1203. There is a fee of $0.25 per page for all Orders.**